

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10655

CERTIFICATE OF DEATH

11743

Reg. Dist. No. 262

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pocomoke</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pocomoke</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>		d. STREET ADDRESS <u></u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>Samuel Henry Ames</u>		4. DATE OF DEATH <u>October 16 1956</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>April 6, 1890</u>	9. AGE (In years last birthday) <u>66</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			

13. FATHER'S NAME <u>HENRY AMES</u>		14. MOTHER'S MAIDEN NAME <u>JANIE TRAVE</u>	
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>	16. SOCIAL SECURITY NO. <u>214-325043</u>	17. INFORMANT <u>Emil Ames Pocomoke, Md.</u>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exhaustion</u> <u>157X</u> DUE TO <u>Vomiting & Dehydration</u> Conditions, if any, which gave rise to immediate cause (b) <u>Ca. of Head & Pancreas</u> lying cause lost. (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u> <u>2 wks.</u> <u>9 mths.</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypoproteinemia due to anorexia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>10/31</u> , 19 <u>55</u> , to <u>10/16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/16/56</u> , 19 <u>56</u> , and that death occurred at <u>8:50 P</u> M, from the causes and on the date stated above.	
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ACTUAL SIGNATURE <u>Emil A. Duverney</u> M.D. <u>801 Fourth St. Pocomoke City, Md</u>	DATE SIGNED <u>10/19/56</u>
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PHYSICIAN'S NAME (Type) <u>Gecil A. Duverney</u>	<u>501 Fourth St Pocomoke City Maryland</u>
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22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-21-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Red Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Painter, VA</u>
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23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar W Horton</u>	ADDRESS <u>New Church, VA</u>	24a. REC'D BY REGISTRAR <u></u>	24b. REGISTRAR'S SIGNATURE <u>Mrs Oville Boyan</u>
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CERTIFICATE OF DEATH

NAME OF DECEASED [Faint handwritten name]		SEX [Faint handwritten sex]		AGE [Faint handwritten age]	
DATE OF DEATH [Faint handwritten date]		TIME OF DEATH [Faint handwritten time]		PLACE OF DEATH [Faint handwritten place]	
CAUSE OF DEATH [Faint handwritten cause]		MANNER OF DEATH [Faint handwritten manner]		PLACE OF BURIAL [Faint handwritten place]	
SIGNATURE OF PHYSICIAN [Faint handwritten signature]		SIGNATURE OF REGISTRAR [Faint handwritten signature]		SIGNATURE OF WITNESS [Faint handwritten signature]	
CITY OF BOSTON [Faint handwritten city]		COUNTY OF SUFFOLK [Faint handwritten county]		STATE OF MASSACHUSETTS [Faint handwritten state]	

BUREAU V. S.

DEC 4 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10655

CERTIFICATE OF DEATH

Reg. Dist. No.

261

1. PLACE OF DEATH a. COUNTY <i>Somerset</i> <i>Marion Station</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Marion, Md.</i>				c. LENGTH OF STAY IN 1b <i>45 yrs</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Phila, General</i>				d. STREET ADDRESS <i>Phila, Pa</i>			
3. NAME OF DECEASED (Type or print) First <i>JOHN</i> Middle <i>HENRY</i> Last <i>BORDEN</i>				4. DATE OF DEATH Oct, 14, 1956			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Apr 23, 1887</i>	
9. AGE (In years last birthday) <i>69</i> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>Somerset</i>							
13. FATHER'S NAME <i>Frank Borden</i>				14. MOTHER'S MAIDEN NAME <i>Sophia Young</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>706-706251</i>		17. INFORMANT Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of the Liver</i> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <i>Sept 15</i> 1956, to <i>Oct 14</i> 1956, that I last saw the deceased alive on <i>Oct 14</i> 1956, and that death occurred at <i>10 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <i>Samuel A. Rose</i> M.D. <i>Crisfield - Md.</i> <i>Oct 15, 1956</i> PHYSICIAN'S NAME (Type) <i>Samuel A. Rose</i> <i>Crisfield - Md.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>10-16-56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Family Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Marion - Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>George H. Tilghman</i>				ADDRESS _____		24a. REC'D BY REGISTRAR DATE <i>10-15-56</i>	
				24b. REGISTRAR'S SIGNATURE <i>Nellie D. Payne</i>			

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11. 11. 1911

2/24. In the morning

Philip Thomas

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7. 10. 1907

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BUREAU V.

OCT 18 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 Film 4206 11-5-56

10656

10657

CERTIFICATE OF DEATH

Reg. Dist. No.

261

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARION STATION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARION STATION			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) WILLIAM First IRA Middle COTTINGHAM Last				4. DATE OF DEATH Month Oct Day 27 Year 1956			
5. SEX MALE		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Marion Sta., Maryland	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME TITHA TH COTTINGHAM				14. MOTHER'S MAIDEN NAME NANCY COTTINGHAM			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 22-26-2807		17. INFORMANT Address Esther Brinkley-Marion-Ind	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis - C. Int. Nephritis 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from at distance , 19 57 , to Oct. 27 , 19 56 , that I last saw the deceased alive on Oct 25 , 19 56 , and that death occurred at M , from the causes and on the date stated above.							
ACTUAL SIGNATURE George C. Coulbourn M.D.				ADDRESS (Street, city or town, state) Marion Sta., Ind DATE SIGNED 10-30-56			
PHYSICIAN'S NAME (Type) George C. Coulbourn, M.D.				Marion Station, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-30-56		22c. NAME OF CEMETERY OR CREMATORY Liberty Cemetery		22d. LOCATION (City, town, or county) (State) Marion, Som Co. Ind.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS George W. Tilghman Marion Sta Ind				24a. REC'D BY REGISTRAR DATE 10/30/56		24b. REGISTRAR'S SIGNATURE Hellie D. Payne	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH: 11-1-56
PLACE OF DEATH: MARYLAND STATE DEPARTMENT OF HEALTH
MARRIAGE STATUS: MARRIED

NAME: MARY ANN STATION
AGE: 22
SEX: F
RACE: WHITE

DATE OF BIRTH: 11-1-56
PLACE OF BIRTH: MARYLAND STATE DEPARTMENT OF HEALTH
MARRIAGE STATUS: MARRIED

DATE OF DEATH: 11-1-56
PLACE OF DEATH: MARYLAND STATE DEPARTMENT OF HEALTH
MARRIAGE STATUS: MARRIED

DATE OF BIRTH: 11-1-56
PLACE OF BIRTH: MARYLAND STATE DEPARTMENT OF HEALTH
MARRIAGE STATUS: MARRIED

DATE OF DEATH: 11-1-56
PLACE OF DEATH: MARYLAND STATE DEPARTMENT OF HEALTH
MARRIAGE STATUS: MARRIED

DATE OF BIRTH: 11-1-56
PLACE OF BIRTH: MARYLAND STATE DEPARTMENT OF HEALTH
MARRIAGE STATUS: MARRIED

DATE OF DEATH: 11-1-56
PLACE OF DEATH: MARYLAND STATE DEPARTMENT OF HEALTH
MARRIAGE STATUS: MARRIED

BUREAU V. 3

NOV 1 1956

RECEIVED

10658

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u>				c. LENGTH OF STAY IN 1b <u>Lifetime</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.F.D. # 1</u>				d. STREET ADDRESS <u>R.F.D. # 1</u>			
3. NAME OF DECEASED (Type or print) First <u>SHERMAN</u> Middle <u>GRAFE</u> Last <u>JUSTICE</u>				4. DATE OF DEATH Month <u>October</u> Day <u>5</u> Year <u>19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 4, 1891</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>For Himself</u>		11. BIRTHPLACE (State or foreign country) <u>Crisfield, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>							
13. FATHER'S NAME <u>Edward T. Justice</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Parks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-12-3362</u>		17. INFORMANT Address <u>Edgar Justice--Rt. # 1--Crisfield, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u> <u>3 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Myocardial Infarction, three episodes</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Feb. 27, 1953</u> , to <u>Oct 5, 1956</u> , that I last saw the deceased alive on <u>Oct 4, 1956</u> , and that death occurred at <u>1:15 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crisfield, Md.</u> DATE SIGNED <u>10/8/56</u> ACTUAL SIGNATURE <u>G. N. Barr, M.D.</u> M.D. <u>Crisfield, Md.</u> PHYSICIAN'S NAME (Type) <u>Dr. A. N. Barr</u> <u>Crisfield, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 8, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sunnyridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Crisfield, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Bradshaw & Sons--Crisfield, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>10/9/56</u>		24b. REGISTRAR'S SIGNATURE <u>Barbara S. Adams</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10658

10659

CERTIFICATE OF DEATH

Reg. Dist. No. 260

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Lans Ave</u>				d. STREET ADDRESS <u>Lans Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Charles Franklin Long</u>				4. DATE OF DEATH <u>Oct 10</u> 19 <u>56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 15 1905</u>		9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Former</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber mill</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>	
13. FATHER'S NAME <u>Frank Long</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Long</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>162x</u> DUE TO <u>Plural Effusion (massive)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchogenic Carcinoma</u> (c) <u>none</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>none</u> p. m. <u>none</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>	
20f. (City or town) <u>none</u> (County) <u>none</u> (State) <u>none</u>							
21. I certify that I attended the deceased from <u>July 10</u> , 19 <u>56</u> , to <u>Oct 10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 10</u> , 19 <u>56</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B. Frank Giganti</u> M.D.				ADDRESS (Street, city or town, state) <u>20 Prince William St. Princess Anne Md.</u>			
PHYSICIAN'S NAME (Type) <u>B. FRANK GIGANTI</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>Oct 13 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Episcopal Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Princess Anne Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Dunbar</u> ADDRESS <u>Princess Anne</u>				24a. REC'D BY REGISTRAR <u>R. J. Johnson, M.D.</u>		24b. REGISTRAR'S SIGNATURE <u>R. J. Johnson, M.D.</u>	

THE UNIVERSITY OF CHICAGO PRESS

BUREAU A

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10660
CERTIFICATE OF DEATH

Reg. Dist. No. **360**

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MANOKIN c. LENGTH OF STAY IN b. 69 YEARS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MANOKIN MARYLAND d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) FANNIE FRANCES MADDOX First Middle Last				4. DATE OF DEATH 10/21/56 Month Day Year											
5. SEX FEMALE		6. COLOR OR RACE COLORED		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/24/1887		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK				10b. KIND OF BUSINESS OR INDUSTRY HOUSE WIFE				11. BIRTHPLACE (State or foreign country) SOMERSET COUNTY MARYLAND. USA				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME BABE DASHIELD				14. MOTHER'S MAIDEN NAME EMMA HARMOND				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. LAURENDA SCOTT MANOKIN MD			
17. INFORMANT LAURENDA SCOTT MANOKIN MD Address															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)															
21. I certify that I attended the deceased from Sept 16, 1956 to Oct 21, 1956 that I last saw the deceased alive on Oct 20, 1956 and that death occurred at 5:17 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Elton G. Marks Princess Anne, Md. DATE SIGNED PHYSICIAN'S NAME (Type) Elton G. Marks Princess Anne, Md.															
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 10/28/56				22c. NAME OF CEMETERY OR CREMATORY John Wesley				22d. LOCATION (City, town, or county) (State) Manokin, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE William H. Jamroz Princess Anne, Md. ADDRESS 24a. REC'D BY REGISTRAR DATE 10/26/56 24b. REGISTRAR'S SIGNATURE R. S. Johnson, M.D.															

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

250

2 weeks

Branch - Johnsons

BUREAU V. 2

5 OCT 29 1956

RECEIVED

File on G. H. Johnson
G. H. Johnson
Oct 29 1956

10661

CERTIFICATE OF DEATH

Reg. Dist. No. 260

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oriole				c. LENGTH OF STAY IN 1b 89 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Kate Middle C. Last Nutter				4. DATE OF DEATH Month Oct. Day 17 Year 186			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1873	9. AGE (in years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Mc Dorman				14. MOTHER'S MAIDEN NAME Leah Heath			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Mr. Percy Nutter Oriole, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial pneumonia 446x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia DUE TO (c) Arteriolosclerosis of kidneys						INTERVAL BETWEEN ONSET AND DEATH 1 week 6 weeks years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1-16-56 , 19____, to 10-17-56 , 19____, that I last saw the deceased alive on 10-17-56 , 19____, and that death occurred at 3p M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Everett C. Sutter				ADDRESS (Street, city or town, state) Dames Quarter Maryland DATE SIGNED 10-20-56			
PHYSICIAN'S NAME (Type) Everett C. Sutter MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10-20-1956		22c. NAME OF CEMETERY OR CREMATORY Oriole Cemetery		22d. LOCATION (City, town, or county) (State) Oriole, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Levin R. Wilson ADDRESS Princess Anne, Md.				24a. REC'D BY REGISTRAR 10/19/56		24b. REGISTRAR'S SIGNATURE R. H. Johnson, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1993

2. *Answer: D*

evening to a long, long day.

2000

U.S. DEPARTMENT OF AGRICULTURE

25

— 7 —

82-31-1

88-71-05

BUREAU V. S.

9561 24 OCT 1956

RECEIVED

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10662

CERTIFICATE OF DEATH

10662

Reg. Dist. No. 360

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>			
c. LENGTH OF STAY IN <u>Life</u>				d. STREET ADDRESS <u>214 Beckford Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>214 Beckford Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Marshall</u> Last <u>Scott</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>31</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 23 1870</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>			
11. BIRTHPLACE (State or foreign country) <u>md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Charles J. Marshall</u>				14. MOTHER'S MAIDEN NAME <u>Priscilla Porter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>			
17. INFORMANT <u>Princess Anne</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> <u>448X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic hypertensive cardiac disease</u> DUE TO <u>arteriosclerotic</u> (c) <u>arteriosclerotic</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 days + 3 years?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Probable carcinomatous (bowel?)</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11-25-55</u> , 19 <u>55</u> , to <u>10-30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct. 30 1956</u> , and that death occurred at <u>7:50 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Geo M. Dunn</u> M.D.				ADDRESS (Street, city or town, state) <u>Princess Anne Md</u> DATE SIGNED <u>11-2-56</u>			
PHYSICIAN'S NAME (Type) <u>George M. Dunn, M.D.</u>				<u>Princess Anne, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11/2/56</u>		<u>Presbyterian</u>		<u>Princess Anne Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Dunman</u> ADDRESS <u>Princess Anne Md</u>				24a. REC'D BY REGISTRAR <u>R. H. Johnson, M.D.</u>		24b. REGISTRAR'S SIGNATURE <u>R. H. Johnson, M.D.</u>	

CERTIFICATE OF DEATH

10000

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		JAN 15 1956		BALTIMORE, MD.	
FATHER'S NAME		MOTHER'S NAME		EDUCATION		RELIGION		MARITAL STATUS		SINGLE	
JAMES H. HARRIS		MARY J. HARRIS		8		METHODIST		MARRIED		MARRIED	
PREVIOUS MARRIAGES		PREVIOUS OCCUPATIONS		PREVIOUS PLACES OF RESIDENCE		PREVIOUS PLACES OF BIRTH		PREVIOUS PLACES OF DEATH		PREVIOUS PLACES OF INTERMENT	
NONE		NONE		NONE		NONE		NONE		NONE	
DATE OF INTERMENT		PLACE OF INTERMENT		NAME OF INTERMENT SOCIETY		NAME OF MINISTER		NAME OF CHURCH		NAME OF FUNERAL HOME	
JAN 15 1956		BALTIMORE, MD.		METHODIST CHURCH		REV. J. H. HARRIS		METHODIST CHURCH		JAMES H. HARRIS	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF MINISTER		SIGNATURE OF CHURCH		SIGNATURE OF FUNERAL HOME		SIGNATURE OF REGISTRAR	

BUREAU V. 2

JAN 15 1956

RECEIVED

10663 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10661

Reg. Dist. No. 860

1. PLACE OF DEATH a. COUNTY <u>SOMERSET</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRINCESS ANNE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westover</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>ALFRED</u> First <u>SMITH</u> Middle <u>SMITH</u> Last		4. DATE OF DEATH <u>OCT 17</u> Month <u>17</u> Day <u>1956</u> Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COL</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 15-1937</u>
9. AGE (In years last birthday) <u>19</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Westover, Som. Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel, Horsey</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE SMITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>R14-34-6019</u>	
17. INFORMANT <u>LOUISE STEVENSON PRINCESS ANNE</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull</u> 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Second and third degree Burns</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Automobile Accident -</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile Accident -</u>	
20c. TIME OF INJURY Month, Day, Year <u>7:20</u> Hour <u>10-17</u> p.m. <u>56</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway 13</u>
20f. (City or town) <u>Princess Anne Somerset Md</u>		(County) <u>—</u> (State) <u>—</u>

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE <u>R. H. Johnson</u>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <u>October 19-1956</u>
EXAMINER'S NAME (Type) <u>R. H. Johnson</u>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>OCT 21-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GREENWOOD</u>	22d. LOCATION (City, town, or county) (State) <u>PRINCESS ANNE SOM, CO MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Hiram Marion Md.</u>		24a. REC'D BY REGISTRAR <u>19-56</u>	24b. REGISTRAR'S SIGNATURE <u>R. H. Johnson MD</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 1

OCT 24 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield				c. LENGTH OF STAY IN 1b 15 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION McCready Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NORRIS Middle JAMES Last TULL				4. DATE OF DEATH Month October Day 23 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 22, 1910	
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months 46 Days 46 Hours 46 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Poultry Grower		10b. KIND OF BUSINESS OR INDUSTRY For Himself	
11. BIRTHPLACE (State or foreign country) Pocomoke, Maryland				12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Edward Tull				14. MOTHER'S MAIDEN NAME Octavia Ritchie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-05-7016		17. INFORMANT Address Mrs. Elizabeth S. Tull-Crisfield, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 411X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis DUE TO (c) Rheumatic Fever - not active.							INTERVAL BETWEEN ONSET AND DEATH 2 days 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct. 1, 1956 , to Oct. 23, 1956 , that I last saw the deceased alive on Oct. 22, 1956 , and that death occurred at 5:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 33 W. Main St Crisfield, Md. DATE SIGNED Oct 25, 1956							
ACTUAL SIGNATURE Sarah M. Peyton M.D.				PHYSICIAN'S NAME (Type) Dr. Sarah M. Peyton Crisfield, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 26, 1956		22c. NAME OF CEMETERY OR CREMATORY Private Family Cemetery		22d. LOCATION (City, town, or county) (State) Crisfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md. ADDRESS				24a. REC'D BY REGISTRAR DATE 10/31/56		24b. REGISTRAR'S SIGNATURE Barbara S. Adams	

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 5 1956

RECEIVED

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10664

10655

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH o. COUNTY <u>Somerset</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crocksfield</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crocksfield md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>McCreedy Hospital</u>				d. STREET ADDRESS <u>Rt 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Blensak</u> First <u>E.</u> Middle <u>Turner</u> Last				4. DATE OF DEATH <u>Oct 20</u> Month <u>20</u> Day <u>1956</u> Year			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 24, 1878</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min.	IF UNDER 24 HRS. Hours <u>1</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Leander James Ward</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Travis Sterleng</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mrs James Webster</u>		Address <u>Baltimore</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Infarction</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiac Disease: Failure</u> (c) <u>Uremia</u> INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>2 days</u>						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. 11. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 15</u> , 19 <u>56</u> , to <u>Oct 20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 20</u> , 19 <u>56</u> , and that death occurred at <u>8:20</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Isaiah Payne</u> M.D.				ADDRESS (Street, city or town, state) <u>33 W. Main Crocksfield Md</u>			
DATE SIGNED <u>Oct 22</u>							
PHYSICIAN'S NAME (Type) <u>James Hunnan</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/23/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ashbury Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Crocksfield md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Hunnan</u>				ADDRESS <u>Crocksfield md</u>		24a. REC'D BY REGISTRAR DATE <u>10/25/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Barbara S. Adams</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH					
JAMES EARL RAY		35		M		W		1921		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES		APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS		TENNESSEE		UNITED STATES					
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S EDUCATION		MOTHER'S EDUCATION		FATHER'S RELIGION		MOTHER'S RELIGION		FATHER'S MARITAL STATUS		MOTHER'S MARITAL STATUS		FATHER'S SOCIAL SECURITY NO.		MOTHER'S SOCIAL SECURITY NO.		FATHER'S EMPLOYER		MOTHER'S EMPLOYER					
JAMES EARL RAY		LUCILLE RAY		FARMER		HOUSEWIFE		HIGH SCHOOL		HIGH SCHOOL		METHODIST		METHODIST		MARRIED		MARRIED		1-000-000-000		1-000-000-000		RAY, JAMES EARL		RAY, LUCILLE					
EDUCATION		OCCUPATION		REASON FOR DEATH		CAUSE OF DEATH		MANNER OF DEATH		IMMEDIATE CAUSE		UNDERLYING CAUSE		MORBIDITY		MORTALITY		MORBIDITY		MORTALITY		MORBIDITY		MORTALITY		MORBIDITY		MORTALITY			
HIGH SCHOOL		FARMER		HEART DISEASE		CORONARY THROMBOSIS		NATURAL		CORONARY THROMBOSIS		CORONARY THROMBOSIS		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE			
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S EDUCATION		MOTHER'S EDUCATION		FATHER'S RELIGION		MOTHER'S RELIGION		FATHER'S MARITAL STATUS		MOTHER'S MARITAL STATUS		FATHER'S SOCIAL SECURITY NO.		MOTHER'S SOCIAL SECURITY NO.		FATHER'S EMPLOYER		MOTHER'S EMPLOYER		FATHER'S EMPLOYER		MOTHER'S EMPLOYER	
JAMES EARL RAY		LUCILLE RAY		FARMER		HOUSEWIFE		HIGH SCHOOL		HIGH SCHOOL		METHODIST		METHODIST		MARRIED		MARRIED		1-000-000-000		1-000-000-000		RAY, JAMES EARL		RAY, LUCILLE		RAY, JAMES EARL		RAY, LUCILLE	

BUREAU V. S.

OCT 29 1956

RECEIVED

10666

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH o. COUNTY <u>Somerset</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>McCready Hospital</u>				d. STREET ADDRESS <u>39</u>			
3. NAME OF DECEASED (Type or print) <u>Rosie</u> First <u>Ward</u> Middle Last				4. DATE OF DEATH <u>Oct.</u> Month <u>18</u> Day <u>19</u> Year <u>56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 14, 1897</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR: Months <u>3</u> Days <u>18</u> Hours <u>19</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Richmond, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Beale</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Winter Hall - Crisfield, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis - with previous episode of hemiplegia</u> DUE TO <u>2 wks -</u> (c) <u>Paralysis agitans</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6-8 hrs -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Paralysis agitans</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> , to <u>Oct.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 18</u> , 19 <u>56</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. G. Rawley</u> M.D.				ADDRESS (Street, city or town, state) <u>Crisfield, Md.</u> DATE SIGNED <u>10/20/56</u>			
PHYSICIAN'S NAME (Type) <u>C. G. Rawley, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Oct 22, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Asbury</u>		22d. LOCATION (City, town, or county) (State) <u>Crisfield - Som. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward - Marion St., Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>10/20/56</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Bartlett J. Brown</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

10667

CERTIFICATE OF DEATH

10667

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chance				c. LENGTH OF STAY IN 1b 1 month			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Chance Maryland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Philip Middle Wright Last Wright				4. DATE OF DEATH Month October Day 14 Year 19 56			
5. SEX male		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 8, 1956	
9. AGE (In years lost birthday) yrs. 1		IF UNDER 1 YEAR Months 7		IF UNDER 24 HRS. Hours 7 Min. 19 56			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? United States							
13. FATHER'S NAME Thomas Gerald				14. MOTHER'S MAIDEN NAME Ruth Wright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Mother Address Chance Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration 571.0 DUE TO Gastroenteritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 3 days (c) 3 days						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10-14-56 , 19____, to 10-14-56 , 19____, that I last saw the deceased alive on 10-14-56 , 19____, and that death occurred at 7:30PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Dames Quarter, Maryland DATE SIGNED ACTUAL SIGNATURE Everett C. Sutter M.D. PHYSICIAN'S NAME (Type) Everett Clayton Sutter							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-15-56		22c. NAME OF CEMETERY OR CREMATORY Private Burial grounds		22d. LOCATION (City, town, or county) (State) Chance Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE No undertaker				ADDRESS		24a. REC'D BY REGISTRAR DATE 10/15/56	
				24b. REGISTRAR'S SIGNATURE Lila S. Wheatley			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2082191XV4

Late because cert. went to Welfare Dept.
10/19/56 MB.

10/19/56 MB

BUREAU A. 8

OCT 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG205 10-10-56 et

10668

CERTIFICATE OF DEATH

Reg. Dist. No.

260

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Yokley</u> Last				4. DATE OF DEATH Month <u>Oct</u> Day <u>3rd</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 1872</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		IF UNDER 48 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>			
11. BIRTHPLACE (State or foreign country) <u>Old Brynville, Tenn.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Jerry Yokley</u>				14. MOTHER'S MAIDEN NAME <u>Jane ?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Dr. Orange Yokley - Princess Anne</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Haemorrhage</u> <u>592X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive</u> (c) <u>Chronic Interstitial Nephritis</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug 24</u> , 1956, to <u>Oct 3</u> , 1956, that I last saw the deceased alive on <u>Oct 3rd</u> , 1956, and that death occurred at <u>11:40 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Eldon G. Marksman</u> M.D.				ADDRESS (Street, city or town, state) <u>Princess Anne</u>			
PHYSICIAN'S NAME (Type) <u>Eldon G. Marksman, M.D.</u>				DATE SIGNED <u>10.3.56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 7, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>East Bernstadt</u>		22d. LOCATION (City, town, or county) (State) <u>London Kentucky</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Edgar Thomas</u> ADDRESS <u>Accomac, Va</u>				24a. REC'D BY REGISTRAR DATE <u>10/3/56</u>		24b. REGISTRAR'S SIGNATURE <u>R. H. Johnson, M.D.</u>	

1



CERTIFICATE OF DEATH

NAME OF DECEASED [Faint handwritten name]		SEX [Faint handwritten sex]		AGE [Faint handwritten age]	
DATE OF DEATH [Faint handwritten date]		PLACE OF DEATH [Faint handwritten place]		TIME OF DEATH [Faint handwritten time]	
CAUSE OF DEATH [Faint handwritten cause]		MANNER OF DEATH [Faint handwritten manner]		PLACE OF BIRTH [Faint handwritten place]	
OCCUPATION [Faint handwritten occupation]		MARITAL STATUS [Faint handwritten status]		COLOR [Faint handwritten color]	
SIGNATURE OF PHYSICIAN [Faint handwritten signature]		SIGNATURE OF REGISTRAR [Faint handwritten signature]		SIGNATURE OF WITNESS [Faint handwritten signature]	
CITY [Faint handwritten city]		COUNTY [Faint handwritten county]		STATE [Faint handwritten state]	
ZIP CODE [Faint handwritten ZIP]		DISTRICT [Faint handwritten district]		BLOCK [Faint handwritten block]	
HOUSE NUMBER [Faint handwritten house number]		STREET [Faint handwritten street]		CITY [Faint handwritten city]	
COUNTY [Faint handwritten county]		STATE [Faint handwritten state]		ZIP CODE [Faint handwritten ZIP]	

BUREAU OF

OCT 5 1956

RECEIVED

RECEIVED

RECEIVED